Chapter 2.3

Mental Health, Mental Illness, and Homelessness in Canada

CANADIAN POPULATION HEALTH INITIATIVE OF THE CANADIAN INSTITUTE FOR HEALTH INFORMATION

Pathways into Homelessness

Homelessness or the risk of homelessness is a harsh reality for many Canadians. It is not confined to any one group in society, but may affect youth, men and women, one- or two-parent families, the elderly, new immigrants, Aboriginal Peoples, and others (Shortt et al., 2006). It is not an individual characteristic, but rather a life circumstance that can be temporary, episodic or relatively long lasting (Begin et al., 1999). At present there is no universally agreed-upon definition of homelessness, nor is there a clear picture of the prevalence and composition of Canada's homeless population.

Studies show that people who are homeless are more likely to experience compromised mental health and mental illness (Hwang, 2001; Public Health Agency of Canada, 2006). For some, these issues can precede the onset of homelessness (Mental Health Policy Research Group, 1997). For others, they can be worsened with continued homelessness (Frankish et al., 2005). At the same time, it is important to note that not all people with mental illness are homeless, and not all people who are

Canadian Population Health Initiative of the Canadian Institute for Health Information, Mental Health, Mental Illness, and Homelessness in Canada. In: Hulchanski, J. David; Campsie, Philippa; Chau, Shirley; Hwang, Stephen; Paradis, Emily (eds.) *Finding Home: Policy Options for Addressing Homelessness in Canada* (e-book), Chapter 2.3. Toronto: Cities Centre, University of Toronto. www.homelesshub.ca/FindingHome

ISBN 978-0-7727-1475-6

homeless report a mental illness. For example, a 1997 Toronto study of 300 shelter users found that while two-thirds of respondents reported a lifetime diagnosis of mental illness (Goering et al., 2002), mental illness was the least reported reason for becoming homeless (4 percent); loss of job or insufficient income to pay rent was the main reason (34 percent) (Mental Health Policy Research Group, 1997).

How Are Mental Health and Homelessness Related?

The terms "mental health" and "mental illness" are sometimes used interchangeably or are seen as two ends of a single continuum. However, many definitions emphasize that mental health is more than the absence of mental illness. For example, the Public Health Agency of Canada (2006) says that, "mental health is the capacity of each and all of us to feel, think and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections and personal dignity" (p. 2).

Many studies show that people who are homeless are more likely to experience compromised mental health and mental illness than the general population (Hwang, 2001; Public Health Agency of Canada, 2006). For some, these issues can precede the onset of homelessness or, through their interaction with other determinants such as income and employment influences, contribute to homelessness (Centre for Addiction and Mental Health, 2003). They may also worsen with continued homelessness (Frankish et al., 2005) or contribute to the duration of homelessness (Centre for Addiction and Mental Health, 2003).

Patterns of mental health can be influenced by a number of factors, including personal coping skills; perceived self-worth; one's social environment; and other physical, cultural and socio-economic characteristics (Public Health Agency of Canada, 2006). Many of these factors may also be related to the risk of becoming or remaining homeless (Canadian Mental Health Association, 1997; Federation of Canadian Municipalities, 2004).

Experts indicate that, through mental health promotion, positive mental health can play a role in one's recovery process. Mental health promotion "empowers people and communities to interact with their

www.homelesshub.ca/FindingHome

ISBN 978-0-7727-1475-6

environments in ways that enhance emotional and spiritual strength" through strategies to increase self-esteem, coping skills, social support, and well-being (Public Health Agency of Canada, 2006, p. 21). Increasingly, Canadian and international studies of the homeless population have examined these aspects of mental health and mental health promotion, particularly among homeless youth. Examples of their findings are highlighted below.

Stress

Studies in Canada and elsewhere suggest that stress levels are higher among the homeless than among the population as a whole. Overall, data from the 2003 Canadian Community Health Survey (CCHS) indicate that 24 percent of Canadian adults report having "quite a lot" of stress (Canadian Institute for Health Information, 2006). Like other similar studies, however, this survey was not administered to homeless populations. Studies involving the homeless often use other measures and are thus not directly comparable. In some cases, comparisons can be made to published scores compiled from the general population; in other cases, studies include non-homeless comparison groups. Two Canadian examples found that:

- In Kitchener-Waterloo, Ontario, street youth reported more stressors in the past year than non-homeless youth (10.4 on average versus 7.2) (Ayerst, 1999).
- In Ottawa, Ontario, homeless male youth reported an overall stress level that was more than two times higher than that reported by a group of non-homeless male youth (Votta & Manion, 2003).

In the U.S., a Los Angeles, California, study involving youth who were homeless or at risk of homelessness found increases in depressive symptoms and substance abuse disorders, as well as poorer self-rated health with increased stress (Unger et al., 1998).

Coping

Coping skills have been linked to health and well-being (Public Health Agency of Canada, 2004). A number of studies have looked at how homeless individuals cope with stress. Research suggests that homeless

www.homelesshub.ca/FindingHome

ISBN 978-0-7727-1475-6

youth have a tendency toward using coping styles and strategies that work to distance them from a stressor rather than actively attempting to solve it. For example:

- In Kitchener-Waterloo, Ontario, a study found that street youth were more likely to engage in substance use and self-harm as a means of coping; non-homeless youth were more likely to cope by talking to someone they trusted or through productive problem-solving (Ayerst, 1999).
- In Ottawa, Ontario, homeless male youth were more likely to use strategies such as avoiding the problem, withdrawing from social networks, and avoiding negative thoughts and emotions to cope than were non-homeless youth (Compas, 1997; Votta & Manion, 2003, 2004) Among homeless youth only, this style of coping was related to depressive symptoms and various internalizing behaviour problems—the latter of which was measured by anxiety/depressive symptoms, withdrawal, and somatic complaints (that is, unexplained physical problems) (Votta & Manion, 2003).
- In Los Angeles, California, homeless male and female youth who reported using such strategies as wishing the problem would disappear or using substances tended to have higher levels of stress, social isolation, symptoms of depression, and poor self-rated health; in contrast, homeless youth who tried to solve a problem or change a situation reported good self-rated health (Unger et al., 1998).
- Likewise, among adults, a U.S.-based study found that homeless men with a persistent mental illness reported significantly less use and effectiveness of cognitive (for example, problem-solving methods), socio-cultural (for example, seeking social support), and spiritual (for example, prayer) coping strategies than did homeless men with an addiction and homeless men dealing with a specific crisis situation (Murray, 1996).

Social Support

Social support has also been linked to health and well-being, and it can play a role in helping people cope with stress (Johnson et al., 2005a; Public Health Agency of Canada, 2004; Thoits, 1995). Examples include the number of social relationships, frequency of contact, connections among

www.homelesshub.ca/FindingHome

ISBN 978-0-7727-1475-6

members of social networks, availability of social support, and the type of support received, for example, emotional support (Thoits, 1995). The evidence about links between social support and mental health are noteworthy, given the reported lack of social support among various segments of the homeless population.

For example, one study in Ottawa, Ontario, found that homeless male youth reported less perceived parental support than non-homeless male youth (Votta & Manion, 2003). Another Ottawa study found that 15 percent of adults living on the street reported receiving no social support (Farrell et al., 2001).

Various studies report associations between social support and mental health outcomes among people who are homeless. As seeking social support can be a way for people to cope, it is not surprising that these findings are similar to those reported in the coping literature. Examples of findings from existing studies involving youth include the following:

- In Toronto, Ontario, compared to street youth with lower levels of social support, street youth with a high level of social support reported a significantly lower mean depression score (Smart & Walsh, 1993).
- Among homeless youth in Los Angeles, California, increased availability of social support was associated with reduced depressive symptoms and better self-rated health (Unger et al., 1998).
- In Washington, D.C., the 26 percent of runaway and homeless youth who did not indicate they had a current social network had higher odds of using illicit drugs and engaging in risky sexual behaviours (Ennett et al., 1999).

Among adults, Nyamathi et al. (2000a) found that 51 percent of homeless women in Los Angeles reported no current substantial source of social support. Compared to these women, homeless women reporting support from individuals who were not substance users reported higher self-esteem, more active coping, greater life satisfaction, and lower levels of both anxiety and depression.

www.homelesshub.ca/FindingHome

ISBN 978-0-7727-1475-6

Self-Esteem

Self-esteem is another factor often discussed in relation to mental health and well-being. A Toronto study found that street youth with high self-esteem reported being less depressed than those with lower reported self-esteem (Smart & Walsh, 1993). A study of youth in substance abuse treatment programs in Ontario found that compared to 66 percent of non-homeless youth, 50 percent of homeless youth reported feeling good about themselves (Smart & Ogborne, 1994). Similar findings have also been noted in international studies. For instance:

- Relative to different groups of non-homeless youth, a study in Sydney, Australia, found that homeless youth scored significantly lower in four areas of self-concept: impulse control (control of aggression, anxiety, resentment, fear), emotional tone (feelings of tension, sadness, loneliness, inferiority), family relations, and level of psychopathology. Among homeless youth, hopelessness was associated with lower overall self-esteem (Miner, 1991).
- Low self-esteem, along with low support from positive sources, higher support from deviant sources (drug-using family/friends or drinking partners), and avoidant coping (for example, withdrawing from others), was significantly related to high mental distress scores among homeless women in Los Angeles, California (Nyamathi et al., 2000b).
- Another Los Angeles study found that 16 percent of street youth reported low self-esteem, which was itself associated with increased risk of both alcohol and drug use and suicidal thoughts/attempts (Unger et al., 1997).

Suicidal Behaviours

Although much remains unknown about the causal pathways between mental health and suicide, suicidal behaviours have been linked to aspects of mental health among homeless individuals. Qualitative studies have found that feelings of hopelessness, loneliness, worthlessness, and being trapped were themes underlying homeless youths' experiences with suicide (Kidd, 2004). Existing research shows an association between suicidal behaviours and coping. Among homeless male youth,

www.homelesshub.ca/FindingHome

ISBN 978-0-7727-1475-6

suicidal behaviours were associated with having a coping style that does not involve actively trying to solve a problem or cope with a stressor (Votta & Manion, 2004).

A number of Canadian studies report higher rates of suicidal thoughts and suicide attempts among homeless youth than among youth who are not homeless. According to the Public Health Agency of Canada (2006), 12 percent of males and 19 percent of females aged 15 to 24 report having had suicidal thoughts at some point in their lifetime. Fewer (2 percent of males and 6 percent of females aged 15 to 24) report having attempted suicide. Findings from studies involving homeless youth include the following:

- A 2006 survey of youth across British Columbia indicated that compared to 4 percent of males and 10 percent of females in schools, 15 percent of males and 30 percent of females who were street-involved and marginalized reported having attempted suicide at least once in the previous 12 months (McCreary Centre Society, 2007).
- In Ottawa, Ontario, compared with 4 percent of non-homeless male youth, 21 percent of homeless male youth reported at least one past suicide attempt. Compared with 34 percent of non-homeless youth, 43 percent of homeless youth reported suicidal thoughts (Votta & Manion, 2004).
- Of homeless youth sampled in Toronto, Ontario, and Vancouver, British Columbia, 46 percent reported a past suicide attempt (Kidd, 2004).
- In Richmond Hill, Ontario, 20 percent of homeless youth reported at least one suicide attempt in their lifetime; 25 percent reported suicidal thoughts (Cameron et al., 2004).

How Are Mental Illness and Homelessness Related?

The Public Health Agency of Canada (2006) defines mental illness as "…alterations in thinking, mood or behaviour—or some combination thereof—associated with significant distress and impaired functioning." (p. 2) Compared with the general population, research shows a greater incidence and prevalence of persons with serious mental illnesses becoming or remaining homeless (Levine, 1984). Other research has documented a higher prevalence of mental disorders among the homeless

www.homelesshub.ca/FindingHome

ISBN 978-0-7727-1475-6

than among the general population (D'Amore et al., 2001). In Toronto, Ontario, 67 percent of shelter users in the Pathways into Homelessness Project reported a lifetime diagnosis of mental illness (Goering et al., 2002).

Schizophrenia and Personality Disorder

In Statistics Canada's 2002 Mental Health and Well-being Survey, less than 1 percent of adults in the general population reported having been professionally diagnosed with schizophrenia (Public Health Agency of Canada, 2006). Canadian and U.S. studies, including the following, report higher rates of schizophrenia among the homeless:

- In Toronto, Ontario, 6 percent of 300 shelter users reported a psychotic disorder, primarily schizophrenia (Mental Health Policy Research Group, 1997).
- A Vancouver, British Columbia, study reported that 24 of 124 shelter users had a mental health problem; of these, 7 identified their mental health problem as schizophrenia (Acorn, 1993).

Toronto's Pathways into Homelessness Project also found that 29 percent of shelter users met criteria for anti-social personality disorder, often in addition to another diagnosis such as depression, post-traumatic stress disorder (PTSD) or psychotic disorder (Mental Health Policy Research Group, 1997).

PTSD is a disorder associated with a traumatic event and characterized by various symptoms, including persistent and recurring thoughts or images and avoidance behaviours (Rothschild, 2000). Research indicates that physical and sexual abuse occurring while people are homeless is a risk factor for the onset of PTSD (Mueser et al., 2004). In a study involving homeless youth, 24 percent met criteria for PTSD; 40 percent who met the criteria for substance abuse disorder also met the criteria for PTSD (Johnson et al., 2005b).

Substance Abuse and Concurrent Disorders

Among the general population, data from Statistics Canada's 2002 Mental Health and Well-being Survey indicate that among females, 4 percent of young women (15 to 24 years of age) and 1 percent of adult women

www.homelesshub.ca/FindingHome

ISBN 978-0-7727-1475-6

(25 to 44 years of age) report alcohol dependence in the previous 12 months. Fewer (2 percent of young women and less than 1 percent of adult women) report illicit drug dependence in the previous 12 months. Rates are higher among males: 10 percent of young men and 4 percent of adult men report alcohol dependence, while 4 percent of young men and 1 percent of adult men report illicit drug dependence in the previous 12 months (Public Health Agency of Canada, 2006).

Canadian studies indicate that rates of substance abuse are higher among homeless individuals than among the general population. For example, in Toronto, Ontario, 68 percent of shelter users reported a lifetime diagnosis of substance abuse or dependence (Goering et al., 2002). Other Canadian studies have found that:

- In Vancouver, British Columbia, 44 percent of homeless adults reported use of non-prescription drugs such as marijuana and cocaine within the past month (Acorn, 1993).
- In Edmonton, Alberta, 40 percent and 55 percent of homeless youth reported drinking alcohol and using marijuana, respectively, at least two to three times a week (Baron, 1999).
- Various Canadian studies also report high levels of opioid and non-opioid drug use among the homeless. For example, in Edmonton, Alberta, 55 percent of street youth reported using at least one of four drugs (cocaine, heroin, amphetamines or tranquilizers) in the past year (Baron, 1999). A Montréal, Quebec, study of street youth over a five-year period noted an incidence rate of drug injection use of 8.2 per 100 person-years among a cohort of 415 street youth (Roy et al., 2003)—at study entry, these youth had never used injection drugs.

Some individuals have both substance abuse disorders and mental illness diagnoses, known as "concurrent disorders" (Shortt et al., 2006). Other terms used include "dual diagnosis," "dual disorder," "comorbidity" or "co-occurring substance abuse disorders and mental disorders"(Centre for Addiction and Mental Health, 2006). Published literature reviews suggest that homeless individuals with concurrent disorders are likely to remain homeless longer than other homeless people (Drake et al., 1991). In Toronto, Ontario, almost all of the shelter users in the Pathways into Homelessness Project who reported a lifetime diag-

www.homelesshub.ca/FindingHome

ISBN 978-0-7727-1475-6

nosis of mental illness also had a substance abuse disorder (Mental Health Policy Research Group, 1997).

Depressive Symptoms and Major Depressive Disorder (MDD)

Research also suggests that depression is more common among homeless Canadians than among others. Among the general population, 14 percent of 15- to 24-year-old females and 17 percent of 25- to 44-year-old females report having been diagnosed with depression at some point in their life. Reported rates are lower among male youth and adults—7 percent and 10 percent, respectively (Public Health Agency of Canada, 2006). Methods used in research among the homeless are not directly comparable, but studies have found that:

- Homeless male youth in Ottawa, Ontario, were more likely than non-homeless male youth to report scores for depressive symptoms (39 percent versus 20 percent) and internalizing behaviour problems (44 percent versus 24 percent) that were within a clinical range. As noted previously, the latter were measured based on the frequency of withdrawal behaviours, symptoms of anxiety/depression, and unexplained physical problems (Votta & Manion, 2003).
- One-third (33 percent) of a sample of Ottawa, Ontario's adult street population self-reported mental health difficulties; of these, 20 percent reported depression (Farrell et al., 2001).
- In Kitchener-Waterloo, Ontario, street youth had a significantly higher mean level of depression than non-runaway youth. About half of the street youth in this study (48 percent) reported a decrease in their depression level since leaving home, while 28 percent reported an increase (Ayerst, 1999).

Research involving the homeless in the U.S. reports a range of findings. For example, one study conducted in a large northwestern U.S. city found that 12 percent of 523 homeless youth reported a diagnosis of depression. Rates of depression were higher among females than males (20 percent versus 7 percent). About three-quarters of those surveyed (73 percent) reported experiencing their first depressive episode before leaving home (Rohde et al., 2001). This variation may reflect a number of issues including the use of different measures for assessing prevalence

www.homelesshub.ca/FindingHome

ISBN 978-0-7727-1475-6

rates (Boivin et al., 2005) or the use of different terminology to reflect symptoms or diagnoses (Susser et al., 1989).

Determining the Status of Mental Health and Mental Illness Among the Homeless

Accurately measuring mental health status and mental illness among Canada's homeless population, as well as their use of appropriate mental health services, is complicated. Methodological issues include:

- the different means by which mental illness among the homeless is defined (Susser et al., 1989), which limits the comparisons that can be made between cities, over time, or with the general population;
- variations in the nature of information reported in terms of specific diagnoses;
- a lack of representative information across the provinces and territories;
- the use of terms such as "mental illness," "mental health problems," "mental health concerns," and "mental health difficulties"—to name a few—interchangeably.

Use of Mental Health Services

Dozens of different mental health services exist, although the types of service available—and the populations to whom they are available—vary across the country. Not everyone with mental health problems uses these services. This is true for both the homeless population and others, although the circumstances may be somewhat different. For example, while two-thirds of homeless respondents in a Toronto, Ontario, study reported having been diagnosed with a mental illness at some time during their life, only 25 percent reported receiving psychiatric outpatient services in the previous year (Mental Health Policy Research Group, 1997). Likewise, homeless men with schizophrenia in New York City, New York, were less likely to report having received assistance with discharge planning for living arrangements, aftercare and finances upon release from hospital than non-homeless men with schizophrenia (Caton, 1995).

www.homelesshub.ca/FindingHome

ISBN 978-0-7727-1475-6

Recent research has also explored the barriers that homeless people report encountering in attempting to get help. A Los Angeles, California, study reported that 218 of 688 homeless youth perceived a need for help with mental health problems; 95 had received help and 123 had not. Those who identified a need for help, but who did not get help, cited various reasons, such as not knowing where or what services to use (53 percent), feeling embarrassed (47 percent), not having money to get to the service (36 percent), fears the service provider would contact family (36 percent) or police/social worker (36 percent), thinking the service would not help (33 percent), and the cost of the service (14 percent) (Solorio et al., 2006).

When the homeless do use services, studies indicate that there may be a tendency to use clinics and emergency departments (EDs). A study of over 2,900 homeless patients in the U.S. found that 63 percent received medical care at locations such as outpatient clinics and shelters in the previous year (Kushel et al., 2001). Published reports put the proportion of the homeless population who have received medical care in the ED in the past year at 32 percent (Kushel et al., 2001) to 40 percent (Kushel et al., 2002). Factors associated with ED use included symptoms of ill health, injuries, substance dependence, and depressive symptoms (among homeless men) (Padgett et al., 1995), as well as being a victim of crime, unstable housing, and medical comorbidity (Kushel et al., 2002).

Data from the Canadian Institute for Health Information (CIHI) indicate that mental health and behavioural disorders account for a larger share of ED visits and hospital stays among the homeless than among the population as a whole (Canadian Institute for Health Information, 2007). (The data track ED use in Ontario and a handful of other centres, as well as hospital use outside of Quebec.) Most of the inpatient hospitalizations tracked for the homeless took place in Vancouver, British Columbia; Calgary, Alberta; and Toronto, Ontario. Toronto accounted for 78 percent of all ED visits by the homeless in Ontario.

Mental health and behavioural disorders were the most common reason for ED visits by the homeless, but were not in the top five reasons for visits by other patients. These conditions accounted for more than one-third (35 percent) of visits by the homeless. Within this category, the most common type of mental disorder was psychoactive substance use

Canadian Population Health Initiative of the Canadian Institute for Health Information
2.3 Mental Health, Mental Illness, and Homelessness in Canada

www.homelesshub.ca/FindingHome

ISBN 978-0-7727-1475-6

(54 percent) followed by "schizophrenia, schizotypal and delusional disorders" (20 percent). Reasons for visits for mental health and behavioural disorders varied for homeless men and women. Psychoactive substance use predominated for men (accounting for 62 percent of visits in this category), but it represented only 30 percent of visits for women. In both cases, "schizophrenia, schizotypal and delusional disorders" was the next most common reason for visits for mental health and behavioural disorders (28 percent for homeless women and 18 percent for men).

Mental diseases and disorders were also the most common reason for acute care hospitalization among the homeless, but were not as common among the rest of the population. In 2005–2006, 52 percent of inpatient hospitalizations among the homeless (outside Quebec) were primarily for these conditions (Canadian Institute for Health Information, 2007).

Mental Health Policy in Canada

Starting in the 1960s, many psychiatric inpatients were discharged to the community when psychiatric hospitals or wards were closed and/or the number of beds in psychiatric facilities reduced (Herman & Smith, 1989; Nelson, 2006; Sealy & Whitehead, 2004). While there is no consensus on the impact of deinstitutionalization on the prevalence of homelessness, some researchers have suggested that deinstitutionalization was associated with the growth of new forms of residential or institutional care (Herman & Smith, 1989) as well as increased rates of homelessness (Commission on the Future of Health Care in Canada, 2002; Nelson, 2006; Public Health Agency of Canada, 2006). It has also been noted that community mental health services did not increase at the same rate as patients were deinstitutionalized (Sealy & Whitehead, 2004).

Traditionally, community mental health programs had a community treatment and rehabilitation focus. Approaches reflected such values as reducing symptoms, preventing hospitalization, professionally prescribed treatment, community-based support, vocational training, and housing with an element of support (for example, group homes and halfway houses). The 1990s saw a shift toward recovery and empowerment that reflected values consistent with the principles outlined in the 1988 federal discussion paper, *Striking a Balance: Mental Health for Canadi-*

www.homelesshub.ca/FindingHome

ISBN 978-0-7727-1475-6

ans: emphasis on recovery, recognizing strengths, consumer choice and control, community integration, informal supports, supported employment, and independent housing with flexible support (National Health and Welfare, 1988; Nelson, 2006).

In May 2006, the Senate's report, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada* (Standing Senate Committee on Social Affairs Science and Technology, 2006) recommended the establishment of a Canadian Mental Health Commission and a national mental health strategy; funding was announced by the federal government in March 2007 (Government of Canada, 2007). The report also noted that affordable housing is a key issue for people living with a mental illness: "the percentage of Canadians who are living with mental illness who need access to [adequate, appropriate, and affordable] housing is almost double the percentage of people in the general population whose housing needs are not being met" (Standing Senate Committee on Social Affairs Science and Technology, 2006, p. 462).

Mental Health Policy at the Provincial Level

Several provinces have developed specific initiatives, plans, or frameworks to guide their policies and services. In many cases, they specifically address issues related to homelessness (for example, the provision of supportive housing). Examples include:

- *British Columbia's Mental Health and Addictions Reform Initiative*. The British Columbia Ministry of Health formed best practices working groups to identify various services and strategies that produce positive health outcomes for individuals. The working group's findings are reflected in BC's *Mental Health Reform Best Practices*, which includes reports specific to housing and Assertive Community Treatment (ACT) (British Columbia Ministry of Health, 2002).
- *Alberta's Mental Health Plan: Advancing the Mental Health Agenda*. This plan highlights strategies targeted to specific population groups, including the homeless. Programs that provide the homeless with access to mental health programs and referral services on-site at shelters or drop-in centres are recommended. The plan also outlines various priority strategies and actions such as the provision of safe

www.homelesshub.ca/FindingHome

ISBN 978-0-7727-1475-6

and supportive housing for individuals with severe and persistent mental health problems (Alberta Mental Health Board, 2004).

- *Manitoba's Mental Health System*. Various housing and community living programs are made available to individuals with mental health problems who may be experiencing difficulties living independently. These programs provide participants with several housing services, including residential care facilities and supportive housing (Manitoba Health, 2007).
- *Ontario's Mental Health Homelessness Initiative*. Announced in 1999, this initiative aimed to "address the housing needs of people with mental illness who were either homeless or at risk of becoming homeless." (pg. 91) A comprehensive evaluation of the first phase of this initiative determined that housing choice/control and housing quality were related to subjective quality of life (Nelson et al., 2007).
- *Quebec's Mental Health Action Plan, 2005–2010*. The goal of this plan is to improve access to quality mental health services for those with mental health disorders and/or those who have a high risk of suicide through action, rehabilitation, accessibility, continuity of services, partnerships, and efficiency. Quebec's Ministère de la Santé et des Services Sociaux is committed to prioritizing access to front-line mental health services and to reducing the stigma often associated with having a mental disorder, so that individuals feel comfortable seeking help. The plan will support the provision of quality mental health services to the entire population (for example, youth, adults, communities and Aboriginal Peoples) (Santé et Services Sociaux Québec, 2005).
- *Newfoundland and Labrador's Framework to Support the Development of a Provincial Mental Health Policy*. As part of this framework, the community resource-based model identifies housing as a key element for supporting the well-being of persons with mental health needs. The framework also aims to incorporate best-practice knowledge in housing and case management services (Government of Newfoundland and Labrador, 2001).

www.homelesshub.ca/FindingHome

ISBN 978-0-7727-1475-6

Mental Health Promotion Among the Homeless: Housing Programs

CIHI's *Improving the Health of Canadians: An Introduction to Health in Urban Places* (Canadian Institute for Health Information, 2006b) highlighted the roles that housing, both as a physical structure and the meaning it holds for individuals, can play in physical and mental health outcomes. It presented evidence of a relationship between the lack of affordable housing and both psychological distress (Cairney, 2005) and increased risk of homelessness (Bunting et al., 2004). Research also shows that securing physical housing resources can be associated with reduced psychological distress among the homeless (Wong & Piliavin, 2001) and play a role in supporting individuals recovering from severe mental illness (Borg et al., 2005).

Different types of housing are available to individuals who are homeless and have mental health issues, such as supportive and supported housing. Housing of this nature tends to be small-scale and focused on rehabilitation and community integration (Centre for Addiction and Mental Health, 2005). Research also indicates that the costs associated with supportive housing are lower than the costs associated with emergency shelters (British Columbia Ministry of Social Development and Economic Security, 2001; Pomeroy, 2005).

Supportive housing includes on-site staff support that varies depending on residents' needs (for example, group homes). Supported housing does not include on-site support staff but does include elements of recovery and empowerment (Centre for Addiction and Mental Health, 2005). Continuum of Care (Treatment First) and Housing First are two models designed to provide housing to the homeless while addressing existing mental health issues.

Continuum of Care Models (Treatment First)

The Continuum of Care model consists of several components. In the first phase, outreach, clients are encouraged to accept a referral to a second-step program such as a shelter or drop-in centre. In the next phase, clients are provided with, and required to take part in, any necessary psychiatric or substance abuse treatment. Permanent housing is made

Canadian Population Health Initiative of the Canadian Institute for Health Information
2.3 Mental Health, Mental Illness, and Homelessness in Canada

www.homelesshub.ca/FindingHome

ISBN 978-0-7727-1475-6

available to participants in the final stage, after treatment is completed (Tsemberis & Eisenberg, 2000; Tsemberis et al., 2004).

Housing First Models

In 1992, Pathways to Housing (PTH) Inc., a non-profit New York City agency, developed the Housing First model (Padgett et al., 2006; Tsemberis & Eisenberg, 2000; Tsemberis et al., 2004). Housing First programs offer those who are homeless and mentally ill immediate access to housing that is not contingent on sobriety or treatment. These programs tend to promote harm reduction (that is, diminish the harm caused by drinking or drug use) instead of requiring abstinence (Padgett et al., 2006). They also offer clients a variety of services through interdisciplinary assertive community treatment (ACT) teams, thereby helping to engage those not reached by more traditional approaches.

Effectiveness of Treatment First and Housing First Programs

A number of studies have documented the effectiveness of the Housing First approach in housing retention among individuals who were homeless and mentally ill. Evaluations have not typically included evaluation of long-term health outcomes.

- A New York City study found that after a five-year period (1993 to 1997), 88 percent of participants in the Pathways to Housing program remained housed, compared with 47 percent of participants in Treatment First programs. This study also found that while dual diagnosis reduced housing tenure among participants in both programs, dually diagnosed participants in the PTH program had a higher housing rate than those in the Treatment First program (Tsemberis & Eisenberg, 2000).
- A recent randomized experiment involving homeless individuals who had a diagnosis of severe and persistent mental disorder found the Housing First approach to be more effective than the Treatment First approach in reducing homelessness (Tsemberis et al., 2003). Another study found that homeless participants with a major mental illness such as schizophrenia or bipolar disorder who were enrolled

www.homelesshub.ca/FindingHome

ISBN 978-0-7727-1475-6

in PTH spent more time in stable housing and less time in hospitals than those in Treatment First programs (Gulcur et al., 2003).

Mental Health Promotion Among the Homeless: Community Mental Health Programs

As the pathways out of homelessness and into secure housing are not always easily found or immediate, there is value in understanding what strategies are effective at promoting mental health and addressing mental illness among individuals experiencing homelessness. Individuals who are homeless and have a mental illness are often reluctant to engage in some of the more traditional, office-based approaches to providing services (Johnsen et al., 1999). As a result, a number of community mental health programs have been developed (Dickey, 2000). Some provide outreach services, while others provide longer-term services in the form of assertive community treatment (ACT), intensive case management (ICM), or service integration.

Outreach Services

Outreach programs serve as a point of first contact for persons not linked to other models of service. They provide assessment and linking to other longer-term services. For example:

- The Psychiatric Outreach Team of the Royal Ottawa Hospital is a multidisciplinary team comprising an addiction worker, an occupational therapist, a psychiatric nurse practitioner, a psychiatrist, a psychologist, a recreational therapist, and social workers. The team provides psychiatric services to the individual who is homeless or at risk of homelessness, as well as to the partner agency serving the particular individual (Farrell et al., 2005).
- The Street Outreach and Stabilization (SOS) program of the Canadian Mental Health Association, Calgary Region, provides individuals who are homeless with help in obtaining mental/health services, financial resources, housing, legal assistance, daily life skills training, transportation training, opportunities for leisure and recreation ac-

www.homelesshub.ca/FindingHome

ISBN 978-0-7727-1475-6

tivities, and information about and access to community resources (Canadian Mental Health Association, 2007).

Most evaluations of outreach programs are of a formative and process nature (number of people served, number of referrals, links to other longer-term services, etc.) and do not look at long-term health outcomes.

Assertive Community Treatment (ACT)

ACT teams, typically comprising psychiatrists, psychologists, social workers, addiction specialists, and other professionals, offer intensive case management and support services for individuals with severe and persistent mental health problems. Services are provided on a long-term basis and often right within the client's home community (Centre for Addiction and Mental Health, 2007).

Evaluation studies indicate that, compared to those receiving traditional health services, homeless individuals living with a severe and persistent mental illness who were ACT program participants had improved housing and clinical outcomes, as well as greater satisfaction with their general well-being, their neighbourhoods, and their health. ACT participants also had fewer psychiatric inpatient hospital days (35 versus 67) and emergency department visits (1 versus 2), and more outpatient mental health visits (103 versus 40)—these findings suggested a shift from crisis-oriented services to ongoing outpatient care (Lehman et al., 1997).

Intensive Case Management (ICM)

ICM is a client-directed form of mental health case management and, like ACT, provides program participants with intensive services and long-term support. Unlike the ACT approach, ICM's services are provided through individual case managers as opposed to a multidisciplinary team (Community Mental Health Evaluation Initiative, 2003; Ontario Community Mental Health Initiative, 2007).

The Community Mental Health Evaluation Initiative (CMHEI) is a six-year multi-site assessment of community mental health programs in Ontario (Ontario Community Mental Health Initiative, 2007). As part of this assessment, a clinical trial in Ottawa compared the service use and

www.homelesshub.ca/FindingHome

ISBN 978-0-7727-1475-6

outcomes of homeless and mentally ill clients receiving ICM to those of clients receiving standard care. Many participants also had other challenges such as concurrent substance abuse (Community Mental Health Evaluation Initiative, 2003; Aubry et al., 2006). Results showed improvements among clients receiving both ICM and standard care in housing stability and community functioning, as well as decreases in hospitalizations and substance abuse. At the 24-month follow-up, ICM clients showed significantly lower levels of housing instability (10 percent versus 27 percent) and fewer hospitalizations (13 percent versus 32 percent) than those receiving standard care (Aubry et. al., 2006; Community Mental Health Evaluation Initiative, 2003; Ontario Community Mental Health Evaluation Initiative, 2007).

Service Integration

Another focus area specific to mental health and homelessness is the integration of various services. In 1993, the U.S. Department of Health and Human Services initiated the 18-site Access to Community Care and Effective Services and Supports (ACCESS) demonstration program as part of a nation-wide agenda to address homelessness among the seriously mentally ill. The goals of the program were twofold: "…to identify promising approaches to systems integration and to evaluate their effectiveness in providing services to this population." (Randolph et al., 1997, pp. 369–370). Findings from the ACCESS demonstration program are presented in many published reports. One study found no differences in mental health status and achievement of independent housing between experimental and control-group clients. However, it did find a positive association among participants enrolled in systems that became more integrated with better housing outcomes (Rosenheck et al., 2002).

Mental Health Promotion Among the Homeless: A Population Health Approach

Mental health promotion strategies, combined with specific treatment for a mental illness, can empower people to achieve well-being, develop healthy relationships, and maintain a form of housing and employment (Public Health Agency of Canada, 2007).

www.homelesshub.ca/FindingHome

ISBN 978-0-7727-1475-6

The links between the determinants of mental health and the determinants of homelessness are interrelated and numerous and indicate a role for continued discussion and action to promote mental health among this population. Strategies to achieve this are related to the population health approach:

- "focusing on the needs of the population as a whole as well as subpopulations with particular needs;
- addressing the determinants of mental health and their interactions;
- basing decisions on evidence of need and the effectiveness of interventions;
- increasing investments on the social and economic determinants of health;
- applying multiple strategies in multiple settings and sectors;
- collaborating across sectors and levels of government;
- employing mechanisms for meaningful public involvement; and
- demonstrating accountability for health outcomes." (Public Health Agency of Canada, 2006, p. 21).

Conclusions

The pathways linking mental health and homelessness are numerous and interrelated. For some individuals, the pathways into homelessness may be upstream, reflecting issues such as housing, income level, or employment status. For others, the pathways may be more personal or individual, reflecting issues such as compromised mental health and well-being, mental illness, and substance abuse. Many of these personal and upstream issues are linked to each other.

Some studies suggest that the homeless are at higher risk for compromised mental health and mental illness. Other research has found that those with compromised mental health or mental illness are more likely to become homeless. As most studies involving the homeless tend to be cross-sectional, it is difficult to identify causal pathways between the onset of mental illness and homelessness.

Improving the Health of Canadians: Mental Health and Homelessness was the first report in a series of three produced by CPHI on the theme of mental health and resilience. Due to scoping restrictions, there were a number of areas the report did not address, including the role of positive

www.homelesshub.ca/FindingHome

ISBN 978-0-7727-1475-6

traits as protective factors against negative mental health outcomes; age and sex differences in the onset of mental illness among the homeless; the impact of the length of time homeless; co-addictions; the impact of development disabilities as a concurrent diagnosis with mental illness; and the prevalence of Fetal Alcohol Spectrum Disorder (FASD). Lastly, given the availability of evidence, the report primarily focused on homeless youth and single adult males. It is important to identify the prevalence of homelessness among other subgroups of the population, along with their mental health issues and needs.

Understanding the link between mental health and homelessness requires consideration of both individual-level factors and the broader social determinants of health. Findings indicate that there may be value in clinical, outreach, and research programs that target specific issues such as coping skills, self-worth, and social support along with interventions and policies that target mental illness, addictions, and the other determinants of homelessness, such as housing, income, and employment. With this understanding, there is a greater opportunity for interventions and policies to address homelessness and the mental health and mental illness issues affecting the homeless.

This chapter contains extracts from the CIHI report titled Improving the Health of Canadians: Mental Health and Homelessness*, released August 2007. This chapter is printed with the permission of CIHI. The full report was prepared by CPHI/CIHI staff Elizabeth Votta, Nadine Valk, Keith Denny, Stephanie Paolin and Anne Markhauser, as part of CPHI's Improving the Health of Canadians three-report series on mental health and resilience. It can be found at http://www.cihi.ca/cphi. © 2007 Canadian Institute for Health Information.*

References

Acorn, S. (1993). Mental and physical health of homeless persons who use emergency shelters in Vancouver. *Hospital & Community Psychiatry*, 44(9), 854-857.

Alberta Mental Health Board (2004). *Advancing the mental health agenda: A provincial mental health plan for Alberta.* Edmonton: Alberta Mental Health Board.

Canadian Population Health Initiative of the Canadian Institute for Health Information
2.3 Mental Health, Mental Illness, and Homelessness in Canada

www.homelesshub.ca/FindingHome

ISBN 978-0-7727-1475-6

Aubry, T., Cousins, B., & Flynn, R. (2006). *The community mental health evaluation initiative in Ottawa* (pp. 1-2). Ottawa: University of Ottawa Centre for Research on Community Services.

Ayerst, S. L. (1999). Depression and stress in street youth. *Adolescence*, 34(135), 567–575.

Baron, S. W. (1999). Street youths and substance use: The role of background, street lifestyle, and economic factors. *Youth & Society*, 31(1), 3–26.

Begin, P., Casavant, L., Chenier, N. M., & Dupuis, J. (1999) *Homelessness.* Ottawa: Parliamentary Research Branch. Retrieved June 26, 2006, from http://www.parl.gc.ca/information/library/PRBpubs/prb991-e.pdf.

Boivin, J. F., Roy, E., Haley, N., & du Fort, G. G. (2005). The health of street youth: A Canadian perspective. *Canadian Journal of Public Health*, 96(6), 432–437.

Borg, M., Sells, D., Topor, A., Mezzina, R., Marin, I., & Davidson, L. (2005). What makes a house a home: The role of material resources in recovery from severe mental illness. *American Journal of Psychiatric Rehabilitation*, 8(3), 243–256.

British Columbia Ministry of Health and Ministry Responsible for Seniors (2002). *B.C.'S mental health reform: Housing—best practices.* Vancouver, B.C.

British Columbia Ministry of Social Development and Economic Security (2001). *Homelessness—causes & effects: The cost of homelessness in British Columbia*. Vancouver, B.C.

Bunting, T., Walks, R. A., & Filion, P. (2004). The uneven geography of housing affordability stress in Canadian metropolitan areas. *Housing Studies*, 19(3), 361–393.

Cairney, J. (2005). Housing tenure and psychological well-being during adolescence. *Environment and Behavior*, 37(4), 552–564.

Cameron, K. N., Racine, Y., Offord, D. R., & Cairney, J. (2004), Youth at risk of homelessness in an affluent Toronto suburb. *Canadian Journal of Public Health*, 95(5), 352–356.

Canadian Institute for Health Information (2007). *Improving the health of Canadians: Mental health and homelessness.* Ottawa.

Canadian Institute for Health Information (2006a). *Health indicators.* Ottawa. Retrieved April 30, 2007, from http://secure.cihi.ca/indicators/june_2006/en/hlthind06_e.shtml.

Canadian Institute for Health Information (2006b). *Improving the health of Canadians: An introduction to health in urban places.* Ottawa.

Canadian Mental Health Association (1997). *Mental health and homelessness: A CMHA Ontario position paper* (pp. 1–4). Ottawa.

www.homelesshub.ca/FindingHome

ISBN 978-0-7727-1475-6

Canadian Mental Health Association (2007). *Our programs: Independent living support, Calgary region*. Ottawa. Retrieved April 11, 2007, from http://www.cmha.calgary.ab.ca/programs/independent_living_support.aspx

Caton, C. L. (1995). Mental health service use among homeless and never-homeless men with schizophrenia. *Psychiatric Services*, 46(11), 1139–1143.

Centre for Addiction and Mental Health (2003). *Current issues in addictions and mental health.* Toronto, Ontario. Retrieved April 23, 2007, from http://www.camh.net/Public_policy/Public_policy_papers/current_issues_paper03.pdf.pdf.

Centre for Addiction and Mental Health (2006). *Information about concurrent disorders.* Retrieved April 23, 2007, from http://www.camh.net/About_Addiction_Mental_Health/Concurrent_Disorders/index.

Centre for Addiction and Mental Health (2007). *More intensive and specialized support*. Retrieved April 27, 2007, from http://www.camh.net/Care_Treatment/Resources_clients_families_friends/Challenges_and_Choices/challenges_choices_intspecsuppor.html.

Centre for Addiction and Mental Health (2005). *Types of housing: Supportive/supported housing*. Retrieved April 30, 2007, from http://www.camh.net/Care_Treatment/Community_and_social_supports/Housing/Types_of_Housing/csru_supportive_ed_housing.html.

Commission on the Future of Health Care in Canada (2002). *Building on values: The future of health care in Canada*. Ottawa: Health Canada.

Community Mental Health Evaluation Initiative (2003, Summer). Community Mental Health Evaluation Initiative. *Helping homeless people with mental illness*, 7, 1–3.

Ontario Community Mental Health Evaluation Initiative (2007). *Making a difference: Ontario's Community Mental Health Evaluation* Initiative. Toronto. Retrieved May 24, 2007, from www.ontario.cmha.ca/cmhei/images/report/Making_a_Difference.pdf.

Compas, B. (1997). Effortful and involuntary responses to stress: Implications for coping with chronic stress. In B. H. Gottlieb (Ed.) *Coping with chronic stress* (pp. 105–130). New York: Plenum Press.

D'Amore, J., Hung, O., Chiang, W., & Goldfrank, L. (2001). The epidemiology of the homeless population and its impact on an urban emergency department. *Academic Emergency Medicine* 8(11), 1051–1055.

Dickey, B. (2000). Review of programs for persons who are homeless and mentally ill. *Harvard Review of Psychiatry*, 8(5), 242–250.

www.homelesshub.ca/FindingHome

ISBN 978-0-7727-1475-6

Drake, R. E., Osher, F. C., & Wallach, M. A. (1991). Homelessness and dual diagnosis. *American Psychologist*, 46(11), 1149–1158 (Reprinted from Alcohol and drug abuse and mental health problems among homeless persons: A review of the literature, 1980–1990, by P. J. Fisher, 1990, Rockville, MD: National Institute on Alcohol Abuse and Alcoholism and National Institute of Mental Health).

Ennett, S. T., Bailey, S. L., & Federman, E. B. (1999). Social network characteristics associated with risky behaviors among runaway and homeless youth. *Journal of Health and Social Behavior*, 40(1), 63–78.

Farrell, S. J., Huff, J., MacDonald, S.-A., Middlebro, A., & Walsh, S. (2005). Taking it to the street: A psychiatric outreach service in Canada. *Community Mental Health Journal*, 41(6), 737–746.

Farrell, S. J., Aubry T., & Reissing, E. (2001). *Street needs assessment: An investigation of the characteristics and service needs of persons who are homeless and not currently using emergency shelters in Ottawa*. Ottawa: University of Ottawa.

Federation of Canadian Municipalities (2004). *Incomes, shelter and necessities* (Quality of life in Canadian communities, theme report #1). Ottawa.

Frankish, C. J., Hwang, S. W., & Quantz, D. (2005). Homelessness and health in Canada: Research lessons and priorities. *Canadian Journal of Public Health*, 96(Suppl. 2), 23–29.

Goering, P., Tomiczenko, G., Sheldon, T., Boydell, K., & Wasylenki, D. (2002). Characteristics of persons who are homeless for the first time. *Psychiatric Services*, 53(11), 1472–1474.

Government of Canada (2007). *Budget 2007: Preserving our environment and modernizing our health care system*. Ottawa: Public Works and Government Services Canada.

Government of Newfoundland and Labrador (2001). *Valuing mental health: A framework to support the development of a provincial mental health policy for Newfoundland and Labrador.* St. John's, NL: Department of Health and Community Services.

Gulcur, L., Stefancic, A., Shinn, M., Tsemberis, S., & Fischer, S. N. (2003). Housing, hospitalization and cost outcomes for homeless individuals with psychiatric disabilities participating in Continuum of Care and Housing First programmes. Homelessness: Integrating international perspectives [Special issue]. *Journal of Community & Applied Social Psychology*, 13(2), 171–186.

Herman, N. J., & Smith, C. M. (1989). Mental hospital depopulation in Canada: Patient perspectives. *Canadian Journal of Psychiatry*, 34(5), 386–391.

Hwang, S. W. (2001). Homelessness and health. *Canadian Medical Association Journal*, 164(2), 229–233.

www.homelesshub.ca/FindingHome

ISBN 978-0-7727-1475-6

Johnsen, M., Samberg, L., Calsyn, R., Blasinsky, M., Landow, W., & Goldman, H. (1999). Case management models for persons who are homeless and mentally ill: The ACCESS Demonstration Project. *Community Mental Health Journal*, 35(4), 325–346.

Johnson, K. D., Whitbeck, L. B., & Hoyt, D. R. (2005a). Predictors of social network composition among homeless and runaway adolescents. *Journal of Adolescence*, 28(2), 231–248.

Johnson, K. D., Whitbeck, L. B., & Hoyt, D. R. (2005b). Substance abuse disorders among homeless and runaway adolescents. *The Journal of Drug Issues*, 35(4), 799–816.

Kidd, S. A. (2004). The walls were closing in, and we were trapped: A qualitative analysis of street youth suicide. *Youth & Society*, 36(1), 30–55.

Kushel, M. B., Perry, S., Bangsberg, D., Clark, R., & Moss, A. R. (2002). Emergency department use among the homeless and marginally housed: Results from a community-based study. *American Journal of Public Health*, 92(5), 778–784.

Kushel, M. B., Vittinghoff, E., & Haas, J. S. (2001). Factors associated with the health care utilization of homeless persons. *Journal of the American Medical Association*, 285(2), 200–206.

Lehman, A. F., Dixon, L. B., Kernan, E., DeForge, B. R., & Postrado, L. T. (1997). A randomized trial of assertive community treatment for homeless persons with severe mental illness. *Archives of General Psychiatry*, 54(11), 1038–1043.

Levine, I. S. (1984). Homelessness: Its implications for mental health policy and practice. *Psychosocial Rehabilitation Journal*, 8(1), 6–16.

Manitoba Health, Mental Health and Addictions Branch (n.d.). *Guide to the Mental Health System in Manitoba*. Retrieved April 25, 2007, from http://www.gov.mb.ca/health/mh/system.html.

McCreary Centre Society (2007). *Against the odds: A profile of marginalized and street-involved youth in BC*. Vancouver, B.C.

Mental Health Policy Research Group (1997, November 3). Mental illness and pathways into homelessness: Findings and implications. Paper presented at the Mental Illness and Pathways into Homelessness Conference, Toronto.

Miner, M .H. (1991). The self-concept of homeless adolescents. *Journal of Youth and Adolescence*, 20(5), 545–560.

Mueser, K. T. Salyers, M. P., Rosenberg, S. D., Goodman, L. A., Essock, S. M., Osher, F. C., Swartz, M. S., & Butterfield, M. I. (2004). Interpersonal trauma and posttraumatic stress disorder in patients with severe mental illness: Demographic, clinical, and health correlates. *Schizophrenic Bulletin*, 30(1), 45–57.

www.homelesshub.ca/FindingHome

ISBN 978-0-7727-1475-6

Murray, R. B. (1996). Stressors and coping strategies of homeless men. *Journal of Psychosocial Nursing and Mental Health Services*, 34(8), 16–22.

Nelson, G. (2006). Mental health policy in Canada. In A. Westhues (Ed.) *Canadian social policy: Issues and perspectives* (pp. 245–260). Waterloo, Ontario: Wilfrid Laurier University Press.

Nelson, G., Sylvestre, J., Aubry, T., George, L. & Trainor, J. (2007). Housing choice and control, housing quality, and control over professional support as contributors to the subjective quality of life and community adaptation of people with severe mental illness. *Administration and Policy in Mental Health & Mental Health Services Research*, 34(2), 89–100.

Nyamathi, A. M., Leake, B., Keenan, C., & Gelberg, L. (2000a). Type of social support among homeless women: Its impact on psychosocial resources, health and health behaviors, and use of health services. *Nursing Research*, 49(6), 318–326.

Nyamathi, A. M., Stein, J. A., & Bayley, L. J. (2000b). Predictors of mental distress and poor physical health among homeless women. *Psychology & Health*, 15(4), 483–500.

Padgett, D. K., Struening, E. L., Andrews, H., & Pittman, J., (1995). Predictors of emergency room use by homeless adults in New York City: The influence of predisposing, enabling and need factors. *Social Science & Medicine*, 41(4), 547–556.

Padgett, D. K., Gulcur, L., & Tsemberis, S. (2006). Housing First services for people who are homeless with co-occurring serious mental illness and substance abuse. *Research on Social Work Practice*, 16(1), 74–83.

Pomeroy, S. (2005). *The cost of homelessness: Analysis of alternate responses in four Canadian* cities. Ottawa: Focus Consulting.

Public Health Agency of Canada (2007). *Canadian Health Network*. Retrieved May 15, 2007, from http://www.canadian-health-network.ca.

Public Health Agency of Canada (2006). *The human face of mental health and mental illness in Canada 2006*. Ottawa: Minister of Public Works and Government Services Canada.

Public Health Agency of Canada (2004). *What Determines Health?*. Retrieved April, 9, 2007, from http://www.phac-aspc.gc.ca/ph-sp/determinants/index-eng.php.

Randolph, F., Blasinsky, M., Leginski, W., Parker, L. B., & Goldman, H. H. (1997). Creating integrated service systems for homeless persons with mental illness: The ACCESS Program. *Psychiatric Services*, 48(3), 369–373.

Rohde, P., Noell, J., Ochs, L., & Seeley, J. R. (2001). Depression, suicidal ideation and STD-related risk in homeless older adolescents. *Journal of Adolescence*, 24(4), 447–460.

www.homelesshub.ca/FindingHome

ISBN 978-0-7727-1475-6

Rosenheck, R. A., Lam. J., Morrissey, J. P., Calloway, M. O., Stolar, M., & Randolph, F. (2002). Service systems integration and outcomes for mentally ill homeless persons in the ACCESS Program. *Psychiatric Services*, 53(8), 958–966.

Rothschild, B. (2000). Overview of Posttraumatic stress disorder (PTSD): The impact of trauma on body and mind. In *The body remembers: The psychology of trauma and trauma treatment* (pp. 3–14). New York: W. W. Norton & Company.

Roy, É., Haley, N., Leclerc, P., Cédras, L., Blais, L., & Boivin, J.-F. (2003). Drug injection among street youths in Montreal: Predictors of initiation. *Journal of Urban Health*, 80(1), 92–105.

Santé et Services Sociaux Québec. (2005). *Plan d'action en sante mentale: La force des liens 2005–2010*. Quebec.

Sealy, P., & Whitehead, P. C. (2004). Forty years of deinstitutionalization of psychiatric services in Canada: An empirical assessment. *Canadian Journal of Psychiatry*, 49(4), 249–257.

Shortt, S., Hwang, S., & Stuart, H. (2006). *Homelessness and health: A policy synthesis on approaches to delivering primary care for homeless persons.* Kingston, ON: Centre for Health Services and Policy Research, Queen's University.

Smart, R. G., & Walsh, G. W. (1993). Predictors of depression in street youth. *Adolescence*, 28(109), 41–53.

Smart, R. G., & Ogborne, A. C. (1994). Street youth in substance abuse treatment: Characteristics and treatment compliance. *Adolescence*, 29(115), 733–745.

Solorio, M. R., Milburn, N. G., Andersen, R. M., Trifskin, S., & Rodriguez, M. A. (2006). Emotional distress and mental health service use among urban homeless adolescents. *Journal of Behavioral Health Services and Research*, 33(4), 381–393.

Standing Senate Committee on Social Affairs Science and Technology (2006). *Out of the shadows at last: Transforming mental health, mental illness and addiction services in Canada*. Ottawa: The Senate.

Susser, E., Conover, S., & Struening, E. L. (1989). Problems of epidemiologic method in assessing the type and extent of mental illness among homeless adults. *Hospital & Community Psychiatry*, 40(3), 261–265.

Thoits, P. A. (1995). Stress, coping, and social support processes: Where are we? What next?. Forty years of medical sociology: The state of the art and directions for the future [Extra issue]. *Journal of Health and Social Behaviour*, 35, 53–79.

Tsemberis, S., & Eisenberg, R. F. (2000). Pathways to housing: Supported housing for street-dwelling homeless individuals with psychiatric disabilities. *Psychiatric Services*, 51(4), 487–493.

www.homelesshub.ca/FindingHome

ISBN 978-0-7727-1475-6

Tsemberis, S. J., Moran, L., Shinn, M., Asmussen, S. M., & Shern, D. L. (2003). Consumer preference programs for individuals who are homeless and have psychiatric disabilities: A drop-in center and a supported housing program. *American Journal of Community Psychology*, 32(3–4), 305–317.

Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health*, 94(4), 651–656.

Unger, J. B., Kipke, M. D., Simon, T. R., Montgomery, S. B., & Johnson, C. J. (1997). Homeless youths and young adults in Los Angeles: Prevalence of mental health problems and the relationship between mental health and substance abuse disorders. *American Journal of Community Psychology*, 25(3), 371–394.

Unger, J. B., Kipke, M. D., Simon, T. R., Johnson, C. J., Montgomery, S. B., & Iverson, E. (1998). Stress, coping, and social support among homeless youth. *Journal of Adolescent Research*, 13(2), 134–157.

Votta, E., & Manion, I. G. (2003). Factors in the psychological adjustment of homeless adolescent males: The role of coping style. *Journal of the American Academy of Child and Adolescent Psychiatry*, 42(7), 778–785.

Votta, E., & Manion, I. (2004). Suicide, high-risk behaviours, and coping style in homeless adolescent males' adjustment. *The Journal of Adolescent Health*, 34(3), 237–243.

Wong, Y.-L. I., & Piliavin, I. (2001). Stressors, resources, and distress among homeless persons: A longitudinal analysis. *Social Science & Medicine*, 52(7), 1029–1042.

www.homelesshub.ca/FindingHome

ISBN 978-0-7727-1475-6